

RIVINGTON HOUSE HEALTH CARE FACILITY
STATEMENTS OF INCOME AND RETAINED EARNINGS
FOR THE YEARS ENDED DECEMBER 31, 2008, 2009, 2010, 2011 & 2012

	Yr. End 12/31/2008	Yr. End 12/31/2009	Yr. End 12/31/2010	Yr. End 12/31/2011	Yr. End 12/31/2012	Yr. End 12/31/2013
OPERATING REVENUES						
Skilled nursing facility						
Net resident revenues	\$42,524,058	\$40,223,338	\$38,198,028	\$36,607,063	\$33,993,968	\$32,707,708
Adult day health care center	<u>\$1,543,510</u>	<u>\$1,609,786</u>	<u>\$2,490,159</u>	<u>\$2,104,515</u>	<u>\$2,155,907</u>	<u>\$1,858,928</u>
Total patient service revenue (net of contractual allowances and discounts)				\$38,711,578	\$36,149,875	\$34,566,636
Provision for bad debts ⁽¹⁾				<u>(\$305,014)</u>	<u>(\$162,428)</u>	<u>(\$352,547)</u>
Net patient service revenue less provision for bad debts				\$38,406,564	\$35,987,447	\$34,214,089
Other operating revenue	<u>\$871,342</u>	<u>\$820,315</u>	<u>\$854,023</u>	<u>\$580,962</u>	<u>\$559,505</u>	<u>\$858,475</u>
Total operating revenues	<u>\$44,938,910</u>	<u>\$42,653,439</u>	<u>\$41,342,210</u>	<u>\$38,987,526</u>	<u>\$36,546,952</u>	<u>\$35,072,564</u>
OPERATING EXPENSES						
Medical and related functions (skilled nursing)	\$16,156,792	\$14,968,465	\$13,964,317	\$13,552,231	\$13,003,843	\$11,164,369
Service departments	\$5,255,369	\$5,129,869	\$5,171,854	\$4,915,786	\$4,895,142	\$4,492,575
Day treatment center	\$991,819	\$1,009,515	\$1,080,544	\$1,188,986	\$1,191,097	\$1,175,478
Administrative and general	\$5,061,524	\$4,647,739	\$4,287,572	\$4,929,936	\$4,308,693	\$4,500,557
Payroll taxes and employee benefits	\$5,358,674	\$5,561,302	\$5,737,070	\$6,036,278	\$5,560,638	\$5,681,210
Depreciation and amortization	\$4,608,291	\$4,353,305	\$3,774,518	\$3,450,893	\$3,237,397	\$3,823,095
New York State revenue assessment	\$2,670,345	\$1,965,702	\$1,662,381	\$2,032,049	\$2,023,149	\$1,939,807
Interest	\$915,588	\$1,933,821	\$2,228,172	\$1,688,346	\$1,384,695	\$461,056
Bad debt	<u>\$396,102</u>	<u>\$283,624</u>	<u>\$622,679</u>	<u>--</u>	<u>--</u>	<u>--</u>
Total operating expenses	<u>\$41,414,504</u>	<u>\$39,853,342</u>	<u>\$38,529,107</u>	<u>\$37,794,505</u>	<u>\$35,604,652</u>	<u>\$33,238,147</u>
Operating gain	<u>\$3,524,406</u>	<u>\$2,800,097</u>	<u>\$2,813,103</u>	<u>\$1,193,021</u>	<u>\$942,300</u>	<u>\$1,834,417</u>
Nonoperating revenues						
Contributions and grants	\$10,189	\$40,422	\$36,000	\$7,948	\$13,255	\$4,066
Investment income (Note 3)	<u>(\$1,828,358)</u>	<u>\$2,847,348</u>	<u>\$1,296,464</u>	<u>\$148,189</u>	<u>\$1,351,380</u>	<u>\$1,559,240</u>
Interest Abatement (Note 11)	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>\$3,923,303</u>
Other revenues	<u>\$53,622</u>	<u>\$27,465</u>	<u>\$3,019</u>	<u>\$1,454</u>	<u>\$2,006</u>	<u>\$133,533</u>
Reserve on intercompany receivables (Note 1)	<u>(\$1,460,095)</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>
Total nonoperating revenues	<u>(\$3,224,642)</u>	<u>\$2,915,235</u>	<u>\$1,335,483</u>	<u>\$157,591</u>	<u>\$1,366,641</u>	<u>\$5,620,142</u>
Change in unrestricted net assets (Exhibit C)	\$299,764	\$5,715,332	\$4,148,586	\$1,350,612	\$2,308,941	\$7,454,559
Provision for bad debts on due from related entities (Note 1)	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>\$968,892</u>
Change in unrestricted net assets after other changes (Exhibit C)	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>--</u>	<u>\$6,485,667</u>
Net assets - beginning of year	<u>\$23,643,535</u>	<u>\$24,143,299</u>	<u>\$29,858,631</u>	<u>\$34,007,217</u>	<u>\$35,357,829</u>	<u>\$37,666,770</u>
Net assets - end of year (Exhibit A)	<u>\$24,143,299</u>	<u>\$29,858,631</u>	<u>\$34,007,217</u>	<u>\$35,357,829</u>	<u>\$37,666,770</u>	<u>\$52,575,888</u>

⁽¹⁾ See independent auditor's report.

Bad debts reclassified, per Accounting Standards Update (ASU No. 2011-07) to be associated with patient service revenue.

The accompanying notes are an integral part of these statements.

Part One: Discussion of Income and Expense Statements

We have previously indicated that the bed usage (occupancy rate) at the Rivington House has been steadily declining over the past decade. The property at this time has a focus on the care and treatment of AIDS patients. Also, as noted, AIDS is now generally considered to be a manageable, chronic, disease, rather than a death sentence. The need for nursing home beds to accommodate the seriously ill or terminally ill AIDS patients has now drastically declined.

Typically, in New York State, revenue to the SNF is derived from either Medicaid, Medicare, long-term care insurance, or private pay. The bulk of the revenue is from Medicaid (which is from New York State and the federal government). However, new regulations in New York State (effective as of May 7, 2014, Medicare Managed Care Programs, Sub-Part 360-10) now require that most Medicaid recipients are required to receive health care services from a Medicaid Managed Care Organization (MMCO). After March 21, 2014, all adults becoming permanent nursing home residents are required to enroll in managed care plans in New York City (upstate requirements are slightly different). Those already in a nursing home before June 1, 2014, will remain on a "fee for service" basis for nursing home care and are not required to join a managed care organization.

At present, there is currently no official policy that determines the rates paid by managed care organizations to nursing homes. Most knowledgeable observers anticipate a transition period of at least two years where nursing homes are based on the existing rates (see chart of 2012 rates). In Medicare, a person can go to any provider that accepts Medicare. With managed long-term care, not every provider (i.e., nursing home) will be in every MCO's network. We believe that, with the few SNFs that service the AIDS-related community, the subject facility will retain at least the level of patients and residents as before the MCO regulations. Nursing homes require a substantial investment in capital expenses. At this time, it is difficult to determine how the MCO will also provide for necessary capital improvements. Prior to the latest regulations, rates had been set at a per diem amount by Medicaid, based on the

services offered at each facility. The subject property is considered to be a "specialty facility" based on the AIDS beds at the property. We have examined the per diem rates at all other AIDS facilities in Manhattan (see charts in *Addenda*, with yellow highlights for applicable, comparable properties). The Medicaid reimbursement rate for the subject property, as of January 1, 2012, is \$462.18 per day patient "Medicare non-eligible rate." This is comparable to most other SNF properties offering the same services. The chart below provides a summary of the comparison rates for Medicare non-eligible patients at facilities specializing in treatment of AIDS patients. We emphasize, again, that these fixed rates are subject to change under the new regulations. However, without a clear directive as to the amount of the current compensation, we are making the assumption that, for this appraisal, overall revenue would be generally equivalent to the prior amounts.

**SUMMARY OF COMPARISON RATES
MEDICARE NON-ELIGIBLE PATIENT RATES
PRIMARILY TREATMENT OF AIDS PATIENTS**

<u>COUNTY</u>	<u>FACILITY</u>	<u>EFFECTIVE DATE</u>	<u>MEDICARE NON-ELIGIBLE RATE</u>
New York	The Robert Mapplethorpe Treatment Facility	January 1, 2012	\$410.06
Nassau	A Holly Patterson Extended Care Facility	January 1, 2012	\$571.39
Bronx	Bronx-Lebanon Special Care Center	January 1, 2012	\$461.10
Bronx	Casa Promesa	January 1, 2012	\$416.56
Bronx	Help PSI Inc.	January 1, 2012	\$374.86
Bronx	Highbridge-Woodcrest Center	January 1, 2012	\$455.56
Suffolk	John J Foley Skilled Nursing Facility	January 1, 2012	\$373.44
New York	Rivington House-The Nicholas A. Rango SNF	January 1, 2012	\$462.18
Kings	Schulman and Schachne Institute for Nursing	January 1, 2012	\$499.59
Bronx	St. Barnabas Nursing Home	January 1, 2012	\$461.98
Richmond	St. Elizabeth Ann's Healthcare Rehab. Cntr.	January 1, 2012	\$451.77
New York	St. Mary's Center Inc.	January 1, 2012	\$443.84
New York	Terence Cardinal Cooke Healthcare Center	January 1, 2012	\$458.35

Private pay rates are not regulated and can vary for each facility. The rates can exceed \$12,000 per month in many parts of New York City. Thus, few patients can typically afford this enormous cost for long. More than 90% of SNF residents in New York State are or become reliant upon Medicaid after a relatively brief period. The charges include basic services, such as room and board, general nursing care, housekeeping, linens, personal care, medical records and services and recreation. Other services, including physical therapy and medications are usually additionally billed, although many pharmaceuticals would be covered in part by the Part D drug program.

As we discussed previously, the bulk of the revenue will now be from a Managed Care Organization, rather than directly from Medicaid. While the flow of revenue should be similar to that derived prior to the new regulations, the system is in a state of transition and it is difficult to determine the future level of gross long-term revenue.

We note that, in New York State, once an individual is institutionalized (a resident of a nursing home) that individual cannot be moved out of that home once their personal resources have become exhausted. Thus, a for-profit SNF that may prefer private pay residents and which offers a higher level of physical plant and range of services will eventually arrive at basically the same ratio of Medicaid patients to private pay residents as any other facility.

Based on our discussion above, we have reviewed the operating history of the Rivington House for the prior five years from Year-End 2008 through Year-End 2013. We find that during those prior six years, the total operating revenue has declined from \$44,938,910 in 2008 to \$35,072,564 as of Year-End 2013, or a reduction of approximately 22%. In fact, the patient revenue declined in every year from 2008 to Year-End 2013.

We found that operating expenses also declined, with the loss of patients. For example, medical and related functions declined from \$16,156,792 to \$13,003,843 by Year-End 2012 and then to \$11,164,369 by Year-End 2013. However, the savings in operating expenses could not make up for the overall loss in operating revenue.

When we view the net operating gain (i.e., net income), exclusive of nominal contributions, investment income and other nominal revenue, the net income to the property has declined from \$3,524,406 at Year-End 2008 to \$942,300 as of Year-End 2012, but then increased to \$1,834,417 by Year-End 2013. This pattern of declining net income has been prevalent for at least the last five years of our review of the statements of income and retained earnings. The unusual increase in 2013 is an anomaly, due to a sharp drop in the cost of medical and related functions.

The Year-End 2011 was \$1,193,021, while the Year-End 2010 income was \$2,813,103. The 2013 amount was \$1,834,417. The average of the three years (excluding 2012) is \$1,946,847. If the net income can be increased to a level of the average of those three years (\$1,946,847), the capitalized value, at 8.5%, would be a more realistic \$22,904,082, (Rd) **\$22,900,000.**

Part Two: Direct Sales Comparison Approach

The sales comparison method often has validity in the analysis of a skilled nursing facility. Thus, we have examined the value of the property on the basis of a group of sales of comparable skilled nursing facilities in the New York area. Value on the comparable sales basis is typically predicated on the price per bed. We note that the sale of a nursing home (residential health care facility [RHCF] or skilled nursing facility [SNF]) differs from the sale of almost any other type of real property, since the purchase price of a SNF reflects both the real estate and the operations within the real estate. In each case, we have found that the sales were from a non-profit, or voluntary owner, to a for-profit, or proprietary purchaser. Our analysis of the comparable sales, therefore, includes the overall value of each property as a nursing home, rather than merely the real estate (the land and building) exclusive of the so-called FF&E (furniture, fixtures and equipment) vital to the SNF operation and the goodwill and name recognition of the existing operation.

Our search for recent sales encompassed the entire New York area, from 2012 to October 2014. The following sales are deemed most applicable to the analysis of the subject property.

RECENT SALES OF SNF PROPERTIES - NYC AND ENVIRONS

NAME	ADDRESS	SALE		PURCHASER	NO.	PURCHASE	PRICE
		APPROVAL	SELLER			(OPERATIONS	PER
		DATE	(TYPE)	(TYPE)	BEDS	& R.E.]	BED
1. Kateri Residence	150 Riverside Dr., NYC	10/11/2012	Voluntary	Proprietary	520	\$80,000,000	\$153,846.15
2. Holliswood Care Center	195-44 Sagamore Av., Qns.	5/7/2013	Voluntary	Proprietary	314	\$33,700,000	\$107,324.84
3. Bishop H. Hucles Nursing Home	1834 Fulton St., Bklyn	7/16/2014	Voluntary	Proprietary	240	\$29,345,000	\$122,270
4. Holy Name Home	1740 84th St., Bklyn	6/16/2011	Voluntary	Proprietary	200	\$17,262,500	\$86,312.50
Average:							\$117,438 ⁽¹⁾

⁽¹⁾ Total average is based on total beds and total purchase price.

DISCUSSION OF SNF SALES

We have found that, generally, larger properties can offer the benefits of economies of scale. This includes almost the same size of administrative staff, including senior executives, for a 200-bed facility as for a 400-bed facility. The savings per bed can be substantial. This also holds true for the maintenance staff, which would have essentially the same amount of HVAC equipment, elevators, etc., for a larger facility as for a smaller one.

This is reflected generally in the price per bed. Various other factors are involved in the price of each sale, but the size of the facility is a major factor.

We find that, on an overall basis, with equal weight being given to each facility, the overall average price per bed is \$117,438. With the dramatic impact of the new Medicaid regulation on the business, we must adjust the sales down by approximately 15%. Thus, \$117,438 less 15% (\$17,616) = \$99,822 per bed. The overall value for the subject property, based on the analysis of recent sales, is as follows:

219 beds @ \$99,822 per bed = \$21,861,018.

(Rd) \$21,860,000

Summary of Values and Reconciliation:

We have analyzed the operations of the subject SNF, known as Rivington House, on the basis of capitalization of income and on recent sales of SNF properties. The property is operated as a voluntary, or non-profit SNF. As we have discussed, due to declining bed usage rates, as well as the inability of Medicaid reimbursement rates to fully meet the increase in operating costs (per bed), the net income has declined for the past several years. Although almost all the recent sales of this type of facility are from a voluntary (non-profit) to a proprietary (for profit) operator, we do not see a substantial increase in net income as a result of any change in the status of the owner/operator. A "for-profit" owner would have to pay full real estate taxes (approximately \$905,049 this year). (See *Assessed Value and Real Estate Tax Analysis* section in appraisal.) We believe that additional revenue from private pay patients would not meet the additional loss of income due to the required payment of full real estate taxes. Further, as we have noted, private pay patients will almost invariably have to eventually rely on Medicaid reimbursements, due to the depletion of personal funds resulting from the high cost of the SNF daily rates. We have also discussed the impact of the new MCO regulations on the SNF revenue.

<u>Part One:</u>	Value as a "non-profit" SNF (as per analysis of actual income and expenses):	\$22,900,000
<u>Part Two:</u>	Value as a "non-profit" SNF (as per recent sales):	\$21,860,000

Conclusion of Value:

Based on our analysis of the recent and potential income and expenses, as well as on our review of recent SNF sales, we conclude to a value of **\$22,900,000**. Emphasis is placed on the capitalization methodology.

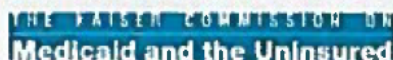
CERTIFICATION

I certify that, to the best of my knowledge and belief,

- The statements of fact contained in this appraisal report are true and correct.
- The reported analyses, opinions, and conclusions are limited only by the reported assumptions and limiting conditions, and are my personal, unbiased professional analyses, opinions, and conclusions.
- I have no present or prospective interest in the property that is the subject of this report, and I have no personal interest or bias with respect to the parties involved.
- My compensation is not contingent on an action or event resulting from the analyses, opinions, or conclusions in, or the use, of this report.
- My analyses, opinions, and conclusions were developed, and this report has been prepared in conformity with the requirements of the Uniform Standards of Professional Appraisal Practice (USPAP) and the Code of Professional Ethics and the Standards of Professional Practice of the Appraisal Institute.
- The use of this report is subject to the requirements of the Appraisal Institute relating to review by its duly authorized representatives.
- As of the date of this report, I, Sheldon Gottlieb have completed the requirements of the continuing education program of the Appraisal Institute.
- I have made a personal inspection of the property that is the subject of this report.
- In the preparation of this appraisal report others assisted in the gathering of the information, comparable sales, inspection of property, etc. However, no one other than the undersigned prepared the analyses, opinions, and conclusions concerning the value of the real estate set forth in this appraisal report.
- I have performed no (or the specified) services, as an appraiser or in any other capacity, regarding the subject property within the three-year period immediately preceding this assignment.



Sheldon Gottlieb, MAI
Certified New York State
General Real Estate Appraiser
Certificate No. 46000000579



Filling the need for trusted information on national health issues...

Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011

Jun 28, 2013

Introduction

Nursing facilities are a major provider of long-term care services in the United States. These facilities provide medical, skilled nursing, and rehabilitative services on an inpatient basis to individuals who need assistance performing activities of daily living, such as bathing and dressing. Nursing facilities are one part of the long-term care delivery system that also includes home and community based services, but their relatively high cost has led them to be the focus of much attention from policymakers. Nationally, spending on nursing facilities across all payers totaled \$143 billion in 2010.¹ The majority of this spending was financed by Medicaid, as most families cannot afford the high cost out-of-pocket and Medicare benefits for these services are very limited.

With the aging of the population in the United States, more individuals will need long-term care services in the future, provided in both the community as well as in facilities. By 2040, 20 percent of the U.S. population will be 65 or older, compared to 13 percent in 2010.² Beneficiary preference as well as cost and quality concerns have driven states to shift long-term care services provided in facilities into the community to reduce Medicaid spending.³ However, as demand continues to increase for long-term care, the characteristics, capacity, and care quality of facilities remain subjects of concern among consumers and policy makers.

This brief examines data from the Online Survey, Certification, and Reporting (OSCAR) system, a database that contains detailed information on Medicaid and Medicare certified nursing facilities. It builds on previous analysis of the OSCAR system,⁴ and looks at the most current year of data, 2011, as well as trends going back to 2006. The brief discusses how data on nursing facilities are collected and

examines a variety of facility characteristics such as facility ownership and number of beds for all 50 states, DC, and the U.S. For additional information on the OSCAR system and methods underlying this analysis, see Appendix 1.

HOW IS DATA ON NURSING FACILITIES COLLECTED?

Nursing facilities are subject to regulation on both the state and Federal level to ensure that quality care is provided to residents. Following studies done on the quality of care in nursing facilities by the Institute of Medicine in the 1980s, Congress passed the Nursing Home Reform Act (OBRA, 1987). The Act was passed with the goal of ensuring that residents receive quality care and certain services to achieve well-being.³ Under the regulations stemming from OBRA, facilities must comply with certain provisions to obtain certification to receive payments from Medicaid and Medicare. These provisions include, among other things, regular resident assessments to be used in care planning and surveys to ensure compliance with Federal regulations related to staffing and quality of life.

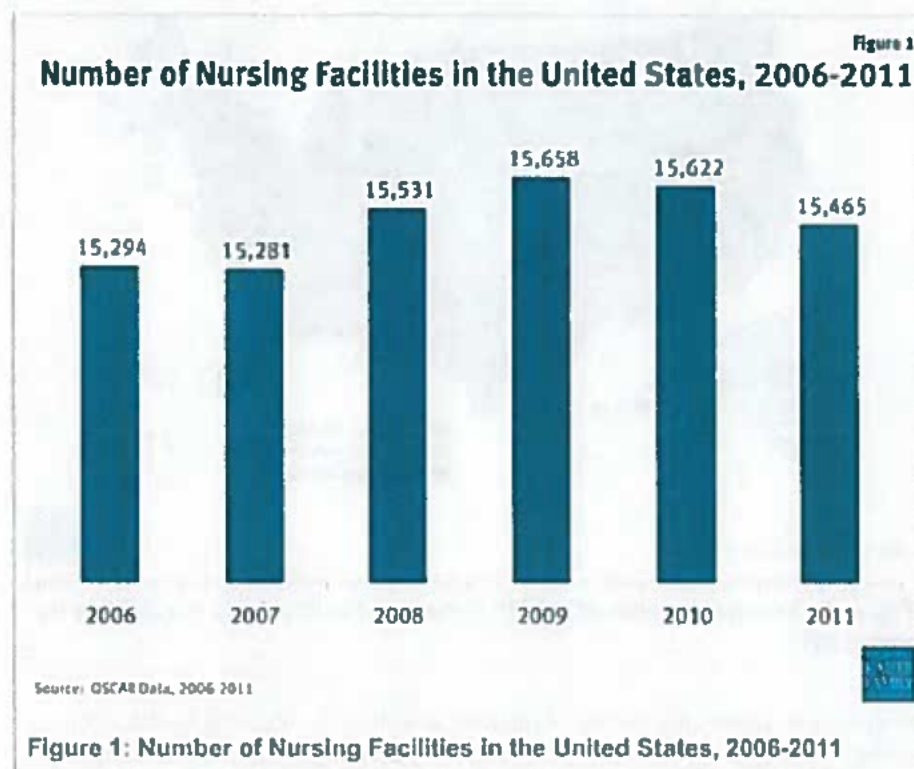
After an initial survey by a state survey and certification agency, facilities are surveyed at least every 15 months to continue certification. Surveys may also be conducted more frequently if needed to determine if facilities have corrected deficiencies, if there are substantial changes in management or reorganization, or if there were complaints related to substandard care. These surveys involve on-site inspections for compliance with about 170 federal regulatory requirements which includes observation, review of facility and resident records, and interviews with residents, staff, and family members. Data from the surveys are compiled to create the federal OSCAR database.

OSCAR contains data on facility, staff, and resident characteristics. The data also contain information on deficiencies related to quality in facilities. System checks are in place to protect against biased surveys and incorrect deficiencies, but under-reporting may still occur. In addition, since each state uses its own surveyors, state differences should be interpreted with caution as inter-survey reliability may be a factor in the reporting on the differences in quality of facilities.

WHAT IS THE CURRENT CAPACITY OF NURSING FACILITIES?

The number and capacity of facilities is critical as sufficient capacity in both institutional and community-based settings are needed to accommodate long-term care user preference. In 2011, 15,465 facilities were surveyed in all 50 states and DC (Table 1).⁴ These facilities contained a total of 1,646,302 beds and served 1.4 million residents at any given time (Table 2). The number of facilities and residents

remains steady from previous years (Figure 1). States vary on the number and size of facilities, which may be a result of different levels of need across states as well as some states shifting more care towards home and community-based settings.



Facilities across the U.S. averaged 108.5 beds per facility in 2011. Facility size has been correlated with quality of care, with research showing that larger facilities often deliver poorer quality of care as compared to smaller facilities.² States vary greatly in average facility size, ranging from an average of 186.0 beds per facility in New York to 42.5 beds per facility in Alaska (Figure 2 & Table 3).

Figure 2
Average Number of Certified Nursing Facility Beds Per Facility by State, 2011

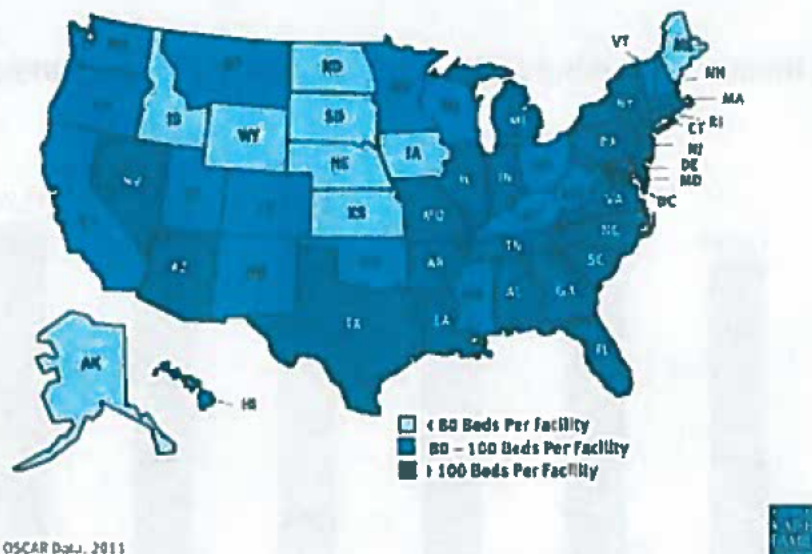


Figure 2: Average Number of Certified Nursing Facility Beds Per Facility by State, 2011

Occupancy rates are an indicator of capacity as well as the financial health of the facility. A facility occupancy rate is calculated by dividing the number of residents in a facility by the number of certified beds (excluding residents in uncertified beds). In 2011, the overall occupancy rate nationwide was 83 percent, but rates varied dramatically across the country with six states having less than 70 percent occupancy while 10 states had more than 90 percent occupancy (Table 4). Overall occupancy rates have declined slightly in the past five years (from over 85% in 2006), despite a slight increase in the total number of residents; these trends may indicate an excess of beds in states with lower occupancy rates.⁸

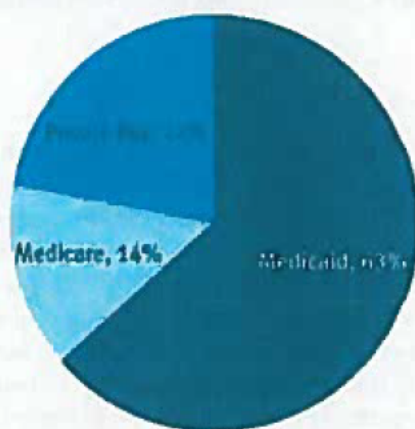
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HOW ARE NURSING FACILITIES FINANCED?

Licensed nursing facilities must be certified to be able to accept Medicare or Medicaid residents, but participation in these programs is voluntary. Medicaid and Medicare have separate certification requirements, and facilities may be certified

for either one or both. In 2011, almost all facilities (95%) were certified for both Medicare and Medicaid (Table 5).

Figure 3
Percentage of Nursing Facility Residents by Primary Payer Type, 2011



1,366,390 Certified Residents

Source: OSCAR Data, 2011



Figure 3: Percentage of Nursing Facility Residents by Primary Payer Type, 2011

Medicaid was the primary payer for over 63 percent of nursing facility residents. Medicaid may become the primary payer of nursing facility services once residents have exhausted or have spent down personal assets paying for care. In addition to Medicaid, 22 percent of residents were private pay, and Medicare accounted for the remaining 14.5 percent of residents (Figure 3). Medicare covers short-term nursing facility stays for residents following a hospital stay, while private pay residents are paying for their care directly out of pocket. Since 2006, the percentage of residents paid for by Medicaid has declined somewhat from 65.4 percent.

Payer mix in facilities is of interest due to research that demonstrated a relationship between high Medicaid occupancy and poor quality in nursing facilities.^{8,10} The decline in the number of Medicaid residents relates to both the shift from institutional-based care to the community as well as a desire for facilities

to increase the share Medicare and private pay residents due to the historically low reimbursement rates from Medicaid (Table 6).¹¹

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Not all states have similar patterns of residents and payers. For example, Medicaid pays for 47 percent of all residents in Iowa, while private sources cover an additional 45 percent of residents. In contrast, in states with similar population sizes, such as Alaska and DC, Medicaid pays for over 80 percent of residents in nursing facilities.

WHO OWNS NURSING FACILITIES?

Nursing facility ownership remains a central focus of research and policy given debate over its relationship with quality of care.¹² Research indicates that for-profit, or proprietary, facilities may have poorer performance on quality measures or lower staffing levels than non-profit or government facilities.¹³ Nationally, 68 percent of facilities are for-profit (Figure 4, Figure 5), but this share varies dramatically by state (Table 7). In some states, including Arkansas, Oklahoma, and Oregon, over 80 percent of facilities are for-profit, while in Minnesota and South Dakota, more than half of facilities are owned by non-profit entities. Government facilities are a small percentage (6%) nationally, but in states like Hawaii and Nebraska, these facilities are more prevalent.

10/27/2014

Overview of Nursing Facility Capacity, Financing, and Ownership in the United States in 2011 | The Henry J. Kaiser Family Foundation



Figure 5
Percentage of For-Profit Nursing Facilities by State, 2011

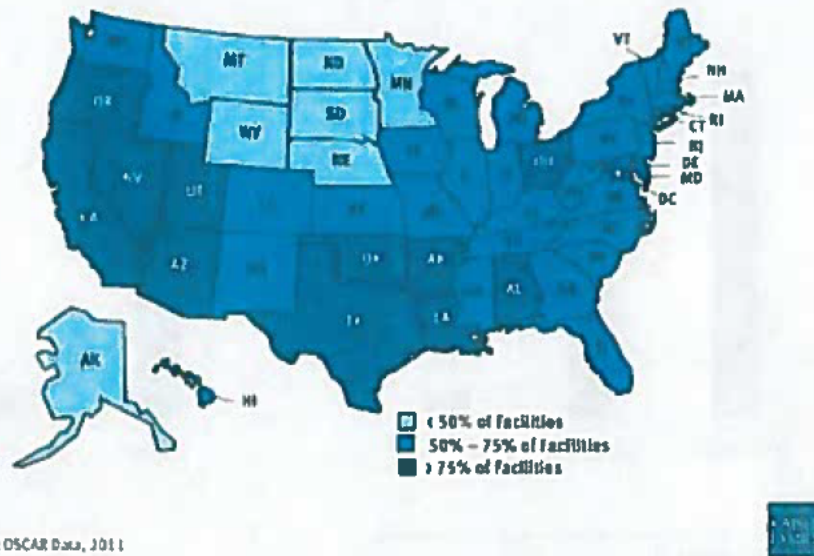


Figure 5: Percentage of For-Profit Nursing Facilities by State, 2011

In addition to ownership, affiliation of facilities has also been linked to staffing levels and quality. Over half of all facilities are owned by chains or corporations that own multiple facilities (Table 8). Chains are typically for-profit entities and have been associated with poor staffing and lower quality.¹⁴ Chain ownership has increased in the last five years, leading policy makers to call for more transparency and additional oversight.¹⁵ Hospital-based facilities make up a small portion of facilities in the U.S., but in certain states, they account for over a quarter of all facilities.

Discussion

Over the last five years, facility characteristics and capacity have remained steady, but with the aging of the population, the demand for long-term care services is increasing. Research has shown that a majority of people over the age of 65 will need long-term care services for an average of three years, and 20 percent of people will need more than five years of services.¹⁶ The percentage of the population over the age of 65 is expected to increase as the "baby boom" generation ages, and

specifically the number of people 85 and older are expected to grow from 5.8 million in 2010 to 19 million in 2050.¹² The next few decades will require states and policy makers to determine sufficient capacity to accommodate long-term care user choice in both institutional and community-based settings.

Home and community-based services have increased over the past decade due to the desire of long-term care users to stay in the community as well as the availability of new and expanded options for states.¹³⁻¹⁶ States, along with the federal government, have responded to these preferences by shifting individuals out of facility based care and into alternatives in the community. Following the *Olmstead* ruling in 1999, states have increased their focus on providing home and community-based services. States provide Medicaid home and community based services through their state plan benefits packages, waivers, and other federal demonstrations such as Money Follows the Person.²⁰ In addition to a preference for services delivered outside of facilities, research has shown that long-term care services, delivered primarily through home and community-based waivers, can provide care at a lower cost.^{21-23,22} States and the Federal government, specifically Medicaid, will continue to be the primary payers of long-term care, in the absence of private insurance options, and will need to evaluate their options in financing these much-needed services.

Facility characteristics, such as ownership, remain important to policy makers and consumers because of their relationship with quality of care. For-profit and chain-owned facilities continue to be the majority of facilities, and concerns about quality of care provided in proprietary facilities persist. A recent U.S. Government Accountability Office report found that nursing facilities that were for-profit or owned by private investment firms were more likely to have deficiencies than non-profit facilities.²⁴ Other studies have found that for-profit facilities may have lower staffing rates as compared to non-profit facilities, which can lead to higher levels of deficiencies.²⁵ States vary in the distribution of facilities by ownership, so continued monitoring of facility ownership is needed by states to ensure a high quality of care is provided at these facilities.

CONCLUSION

Nursing facilities are one part of the long-term care delivery system that provides services to individuals who need assistance performing activities of daily living. With Medicaid as the primary payer for these services, states and the Federal government have an interest in the capacity and financing of the care provided in these facilities. Preferences for home and community-based services as well as

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concerns about ownership and quality remain important issues for policy makers and consumers over the next few years. Data from OSCAR and other sources will continue to provide necessary information to inform decision making.

TABLE 1: TOTAL NUMBER OF CERTIFIED NURSING FACILITIES IN THE U.S. BY CALENDAR YEAR

STATE	2006	2007	2008	2009	2010	2011
AK	13	15	14	15	15	16
AI	179	161	212	210	228	228
AR	236	217	236	211	241	236
AZ	132	174	131	115	138	141
CA	1,189	1,197	1,240	1,226	1,229	1,295
CD	202	209	205	212	211	181
CT	237	233	231	241	234	237
DC	20	18	19	19	18	19
DE	42	44	45	48	47	46
FL	671	657	671	673	683	684
GA	351	346	358	355	338	282
HI	46	41	45	48	41	38
IA	435	430	444	445	442	541
ID	74	70	79	79	79	79
IL	764	787	777	789	784	779
IN	497	502	506	495	509	511
KS	347	331	345	337	319	340
KY	291	289	286	282	284	280
LA	274	282	285	286	282	282
MA	452	428	415	431	429	420
MD	225	216	227	230	216	225
ME	110	108	110	107	105	107
MI	411	421	415	426	429	427
MN	374	378	381	387	386	381
MO	506	502	511	515	512	512
MS	202	200	191	201	202	201
MT	85	85	91	87	86	84
NH	420	414	416	427	423	411
ND	81	80	81	84	86	84
NE	221	208	215	226	222	217
NH	76	81	74	80	80	77
NJ	350	354	357	358	362	362
NM	70	70	69	71	70	68
NV	42	43	47	50	50	51
NY	641	618	640	616	614	611
OH	928	918	950	962	963	945
OK	127	116	125	122	119	117
OR	133	134	124	137	138	129
PA	709	711	700	715	712	713
RI	87	85	84	82	85	85
SC	167	169	171	179	185	188
SD	107	106	100	110	111	111
TN	216	215	212	214	220	202
TX	1,106	1,149	1,153	1,174	1,191	1,227
UT	90	84	96	97	95	67
VA	768	768	781	781	787	786
VT	40	38	40	39	40	40
WA	232	238	232	234	231	231
WI	374	388	396	381	394	391
WV	109	121	131	122	84	91
WY	35	38	39	38	38	30
US	15,294	15,281	15,531	15,658	15,622	15,465

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TABLE 3: AVERAGE NUMBER OF CERTIFIED NURSING FACILITY BEDS IN THE U.S. BY CALENDAR YEAR

STATE	2006	2007	2008	2009	2010	2011
AK	31.6	48.1	49.9	47.7	45.5	42.5
AI	118.6	110.6	117.4	116.4	116.9	116.8
AR	104.0	104.1	104.1	106.1	104.5	105.2
AZ	119.9	117.5	120.5	119.1	117.9	115.1
CA	96.4	97.6	97.5	96.9	97.7	97.9
CO	93.7	94.6	94.4	94.2	95.6	93.2
CT	122.7	122.0	125.0	121.8	121.8	121.3
DC	149.4	144.3	145.5	146.1	131.8	145.9
DE	108.1	106.5	108.6	106.2	112.7	107.7
FL	121.1	124.1	121.6	121.2	121.2	121.4
GA	110.2	110.9	111.1	111.3	110.9	114.6
HI	89.7	90.6	92.2	88.2	80.8	90.1
IA	74.0	71.4	73.4	73.3	72.6	72.4
ID	77.7	78.0	77.9	78.0	77.9	77.5
IL	129.3	128.5	128.8	128.4	127.9	128.7
IN	111.5	112.5	113.2	113.6	113.2	115.0
KS	71.1	75.0	74.7	75.7	75.5	74.5
KY	89.1	89.0	89.9	91.3	91.8	91.0
LA	127.3	125.2	124.7	127.8	127.3	128.0
MA	111.0	111.6	112.4	114.1	114.7	115.6
MD	125.5	127.7	126.9	125.9	125.7	126.4
ME	65.4	64.7	65.5	63.1	63.8	65.9
MH	111.9	110.9	113.1	109.9	110.3	109.8
MI	89.9	87.2	86.2	85.0	83.4	81.9
MO	104.6	104.8	104.2	107.2	107.6	106.7
MS	90.5	91.0	91.7	91.0	91.7	91.3
MT	73.0	71.9	72.2	70.1	60.8	61.1
NC	103.3	105.2	103.5	104.0	104.9	104.7
ND	78.4	74.4	76.9	75.4	75.5	75.7
NE	77.6	73.1	72.2	71.8	71.9	73.2
NH	93.0	91.7	91.3	96.8	96.8	99.8
NJ	142.7	140.4	142.1	141.9	141.8	143.0
NM	95.4	95.1	96.1	96.2	95.8	96.8
NV	119.5	118.2	120.4	116.8	118.9	117.0
NY	185.7	185.1	185.0	190.2	184.3	186.0
OH	96.3	97.1	97.4	96.8	96.5	96.4
OK	90.6	90.9	92.2	92.0	92.5	91.2
OR	90.1	90.7	90.6	89.9	89.3	88.3
PA	123.3	122.8	124.5	124.3	124.9	125.0
RI	102.7	101.2	103.3	103.4	102.5	103.3
SC	104.5	105.9	104.3	106.9	104.9	104.5
SD	61.2	60.3	61.1	66.7	67.6	59.3
TN	115.2	113.5	116.2	114.8	118.0	116.9
TX	108.8	109.6	110.1	110.9	111.6	110.9
UT	82.0	81.1	83.5	81.6	81.3	87.3
VA	114.5	112.4	112.4	113.4	113.0	112.8
VT	84.6	85.9	82.1	82.3	81.9	81.3
WA	91.1	91.8	94.4	93.5	95.2	95.0
WI	95.6	95.1	94.0	92.2	91.5	90.2
WV	82.0	81.1	81.3	85.2	85.8	89.3
WY	81.6	78.2	76.7	78.3	78.0	77.2
US	107.8	107.9	108.3	108.4	108.4	108.5

<http://kaiserfamilyfoundation.files.wordpress.com/2013/06/8-156-table-3.png>